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Dear Colleagues:

Welcome! This is the first issue of a new feature of the *MMWR* on chronic disease prevention activities in the states, at CDC, and in other Federal and private agencies. At the First National Conference on Chronic Disease Prevention and Control, many of the participants asked for a mechanism through which they could learn of activities in other states and communities. We hope *Chronic Diseases Notes and Reports (CDNR)* will help meet that communication need.

Over the last 2 decades, much has been learned about the causes and prevention of many of the leading chronic diseases. However, much of this knowledge is not being widely utilized in large segments of the population at risk of these conditions. It is the responsibility of the medical and public health community to assure that modern prevention technology is effectively and broadly applied. Private physicians, health maintenance organizations, and other primary providers of care will need to routinely make use of preventive services, screening tests, and advice and counseling that translate the fruits of basic research into practice. For minority and other underserved populations in whom risks for many chronic diseases are great, the responsibility of health professionals is especially acute. As with infectious illness for which important control measures such as sanitation and food-service inspection are applied outside the traditional medical-care system, many effective strategies for preventing and controlling chronic diseases are implemented through other means, for example, school health education and public policies for smoking restriction. In these areas the need for leadership from the public health community is clear. Often, however, these kinds of programs are overlooked or ignored in the medical and scientific literature.

It is our hope that *CDNR* can serve as a forum for the exchange of information about effective programs at the state and local levels, whether carried out by health departments, voluntary organizations, occupational or private medical groups, or ideally, coalitions of these. In addition, we will summarize relevant activities here at CDC and elsewhere in the Federal Government. We believe that with your help this can become a valued regular feature of the *MMWR*. I ask not only for your help in providing information for inclusion in *CDNR*, but also for your feedback on what articles you find most useful and what you would like to see emphasized. With such a dialogue, a spirit of collaboration can be achieved, and the potential of *CDNR* realized.

Sincerely,

James O. Mason

James O. Mason, M.D., Dr.P.H.
Director, CDC

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Affairs of State

Health Is on the Way — North Carolina

There is talk and there is action. In the field of health promotion, North Carolina is taking action. As the 1987 Session of the North Carolina General Assembly draws to a close, an act to establish a statewide health promotion and disease prevention program (Senate Bill 95, House Bill 143) is under consideration. The bill would authorize the North Carolina Department of Human Resources to establish, administer, and coordinate a statewide health promotion and disease prevention program focusing on cardiovascular disease, cancer, injuries, and other leading causes of death and disability.

Legislation

The Health Promotion and Disease Prevention Bill would appropriate approximately $3.3 million for fiscal year 1987-1988 and $4.5 million for 1988-1989 for the program. The funds would be awarded to local health departments or, when appropriate, to other public and private organizations, institutions, and agencies, to establish community-based health promotion and disease prevention programs covering North Carolina's 100 counties. The local health departments are designated to coordinate the programs in conjunction with community groups and local agencies. These programs would do the following:

- Identify risk factors associated with cardiovascular disease, cancer, injuries, and other leading causes of death.
- Improve the awareness of individuals and communities about controlling risk factors associated with cardiovascular disease, cancer, injuries, and other leading health problems.
- Promote changes in life-styles and environment likely to reduce such risk factors.

To support the program, the North Carolina Department of Human Resources would provide technical assistance and consultation and training to local health departments. It would also work with the university community to develop a system to monitor and evaluate programs.

History

Responding to House Bill 1052, which was introduced in May 1985 by Representative Sidney Locks, the Legislative Research Commission of the N.C. General Assembly undertook a study to explore innovative approaches to financing health promotion and disease prevention in North Carolina. The commission established a Preventive Medicine Committee, co-chaired by Representative Jeff Enloe of the House and Senator William Martin of the Senate, to make recommendations on this issue.

To develop its position on health promotion and disease prevention, the Preventive Medicine Committee sought testimony from the state's public health, medical, and university communities and from other groups whose constituents would benefit from the program, including the American Association of Retired Persons, General Baptist State Convention, health insurers, and health maintenance organizations. Also, the N.C. Department of Human Resources used data such as years of potential life lost and subsequent losses in lifetime state taxes to show legislators and decision-makers the health and economic impact of chronic diseases and injuries on state resources. The message was clear and consistent:

- Too many people are dying too young of conditions that could be prevented or delayed.
- One-third of deaths in the state occur among persons 18-64 years old.
- Heart disease, cancer, strokes, and injuries lead the list of unnecessary killers.

The Committee developed an appropriations bill with the full support of the Legislative Research Commission. The bill was presented simultaneously in both houses of the General Assembly and was favorably reported out of the joint Human Resources Appropriations Subcommittee on July 3, 1987. Final decisions on the state's budget are pending.

From its inception, this bill has gained broad-based support. The Preventive Medicine Committee has kept the bill moving in the General Assembly. The Local Health Directors Association has gained the endorsement of the N.C. Association of County Commissioners and that of other key groups for this bill. Representatives from the groups that initially endorsed the idea of the statewide program have actively supported the bill as it has progressed through the General Assembly. If successful, this innovative legislation could mark the beginning of a national trend, as states channel resources into enhancing local capacities for effective health promotion.

Editor's Note: As this publication goes to press, a total of $1.2 million has been approved by the North Carolina General Assembly for the statewide Health Promotion and Disease Prevention Program. Action to implement the program is under way in the Adult Health Services Section, Division of Health Services, North Carolina Department of Human Resources. For further information, contact Meredith Cosby, M.P.H., Health Promotion Branch Head, (919) 733-7081.

Surveillance Focuses on Chronic Diseases

In its mission to reduce morbidity and mortality associated with chronic diseases, CDC has intensified its efforts in the surveillance of chronic disease problems, especially those with major public health impact and with a known preventable component. Epidemiologic surveillance is essential to set priorities and guide chronic disease prevention and control programs. Monitoring is needed for the diseases (morbidity and mortality), the determinants of disease (behaviors, environmental exposures, health practices), and the associated burden of disease (disability, cost).

The following are brief descriptions of ongoing, new, or proposed chronic disease surveillance activities that involve collaboration between CDC and states. This is not a comprehensive list but highlights some of the varied approaches that CDC is taking in partnership with state health departments.

- California, Wisconsin, and Maine are collaborating with the Center for Environmental Health (CEH) and the Epidemiology Program Office (EPO) to develop the Chronic and Sentinel Diseases Surveillance system. The goals of this system are to establish priorities for chronic disease surveillance, identify and develop information sources (e.g., hospital discharge records, cancer and other disease-specific registries, vital records, provider-based surveillance systems), develop analytic methods, characterize trends in chronic disease occurrence, and develop coalitions among state agencies, health care providers, and voluntary organizations.

- As a supplement to the above project, Wisconsin is working with CEH, EPO, and the National Institute for Occupational Safety and Health (NIOSH) to examine the usefulness of computer records from a large health maintenance organization. This project will emphasize the surveillance of chronic disease problems that are diagnosed and treated in ambulatory and hospital settings.

- Thirty-five states participate in the Behavioral Risk Factor Surveillance System of the Center for Health Promotion and Education (CHPE). States survey by telephone a randomly selected sample of adults about health behaviors that relate to the leading causes of death in the United States. The data permit health departments to measure risk factor prevalence and to monitor the effect of interventions.

- In cooperation with numerous state health departments, NIOSH is supporting programs for surveillance of occupational conditions, including chronic diseases. Current cooperative agreements with 11 states are directed toward capacity-building in occupational surveillance and exploring existing data sources, such as vital records, as sources for surveillance data. Before the end of 1987, NIOSH plans to offer cooperative agreements to two to five additional states to develop and/or refine targeted, sentinel provider-based reporting systems for selected occupational disorders. This Sentinel Event Notification System for Occupational Risks (SENSOR) program will be based in state health departments and will include intervention and prevention activities directed at reported cases, co-workers of affected persons, and workplaces. SENSOR focuses on the following conditions as particularly appropriate for reporting and follow-up: carpal tunnel syndrome, elevated blood-lead levels, noise-induced hearing loss, occupational asthma, pesticide poisoning, and silicosis.

- The Center for Prevention Services supports diabetes control programs in 30 states to prevent or control four major complications of diabetes: retinopathy, amputations, adverse pregnancy outcomes, and coexistent hypertension. The programs enhance care provided to people with diabetes. Although the main focus of these programs is service delivery, information is being collected to permit evaluation of these complications among the populations served.

Other surveillance activities at CDC cover a number of chronic disease problems, such as congenital anomalies and developmental disabilities, reproductive cancers, coal workers' pneumoconiosis, lead poisoning, virus-associated cancers, and causes of premature mortality. CDC programs are exploring other state, Federal, and private information sources for use in chronic disease surveillance. The National Center for Health Statistics (NCHS), which has recently become part of CDC, collects vital statistics from each state and conducts large-scale population and provider surveys on a wide range of health problems and issues. In addition, CDC's Surveillance Coordination Group is increasing ties with other Federal agencies that collect and use health information and with state and local health organizations.

As demonstrated by both existing and developing systems, chronic diseases are an increasingly important focus of epidemiologic surveillance at CDC. We hope that the models under development can serve as useful examples to other states considering expanding their chronic disease surveillance.

Contributed by Carol A. Ciesielski, M.D., and James W. Buehler, M.D., Epidemiology Program Office, CDC.

Chronic Diseases Notes & Reports **is a special feature of the MMWR, which is prepared by the Centers for Disease Control, Atlanta, Georgia. The contents are in the public domain and may be reproduced and distributed without permission. The editor welcomes contributions and comments from readers. These should be addressed to: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.**

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PATCH Works

In 1985, West Virginia's Monongalia County lacked a coherent approach to health promotion and education. Various health agencies and other organizations sometimes sponsored health promotion programs, but without being certain what the community needed. Needs assessment took time and money, and resources were limited. Health professionals were doing their best, but without broad-based community support, their efforts often seemed ineffectual.

That situation began to change in December 1985, when CDC public health advisor Ron Stoddard of the Center for Health Promotion and Education was asked to introduce a local group to a Planned Approach to Community Health, or PATCH. After much preparation, Monongalia County's PATCH program officially began in May 1986. More than a year later, Sally Taylor, the local coordinator, says: "PATCH is certainly working in our community." A nurse and health educator with the Monongalia County Department of Health, Ms. Taylor adds, "There's just no other program that so closely combines health education and disease prevention."

Participants

PATCH is designed to enhance health promotion and education in communities by combining the efforts of state and local health departments, community members, and CDC representatives. A PATCH community may be a city, county, district, or region. The process begins when a state health department decides to join and commit resources to the PATCH program. The health department is then asked to identify an initial PATCH community, to offer technical assistance and support to communities, to replicate the program in at least one other community, and to work with CDC and use its materials. Also, the state health department is responsible for training participants and coordinating working sessions during the replication process.

West Virginia has been a pioneer in the use of PATCH programs. Matoaka, in Mercer County, was the first of its seven PATCH communities. West Virginia's state coordinator Robert Anderson, Acting Director of the Division of Health Promotion, notes, "State involvement has been quite extensive. We committed ourselves to working with every site."

Further commitments are made at the community level. Three local health workers must volunteer to participate in PATCH, usually donating about 50% of their time to the project. (The employers of all three of Monongalia County's local coordinators allowed them to devote work time to the project. Without their cooperation, the program could not have moved as quickly.) Then a "core group" is formed—three or more people willing to make a long-

term commitment to the effort. In Monongalia County, for example, the core group is a committee of 18. The group includes a legislator, a minister, health educators, the head of the county extension service, and members of the West Virginia University faculty. This group helps the local coordinator administer the program and identify local resources; it also aids in intervention programs.

The final component of the PATCH network is the community group, made up of interested citizens, local officials, and representatives of service organizations and private companies. This group participates in developing program objectives, serves on working committees, and helps implement program activities. Enthusiastic community response has been instrumental in the success of the Monongalia County program. "We've had tremendous support," says Sally Taylor. "People are coming to us and asking, 'Can I be involved?' So we're signing up PATCH partners." These members support and broaden the core committee.

Step by Step

The first task of the major program participants is to introduce the community to PATCH and to mobilize local support for it. Sally Taylor's group chose a media blitz to familiarize the area with PATCH. The group also sponsored a meeting of area mayors and a county commissioner, who jointly declared a PATCH awareness week. These events sparked public interest.

Community diagnosis is the next step in the process. CDC and state health department personnel train local workers to analyze and use data to identify local health problems. Program participants collect morbidity and mortality data, conduct a community opinion survey, and perform a behavioral risk factor prevalence survey. Using these tools, the community sets its own health priorities. Like the majority of PATCH communities that have set objectives, the Monongalia County program identified the prevention of heart disease as its first priority. Three behavioral risk factors have been targeted: sedentary lifestyle, smoking, and alcohol abuse.

After identifying the behaviors that contribute to the community's health problems, PATCH workers begin to locate community resources already committed to preventing the targeted behaviors. The Monongalia County group, for instance, has just begun evaluating responses to a questionnaire on proposed interventions mailed to 225 community leaders and agencies. Several agencies have volunteered their services.

Interventions

Finally, intervention strategies are planned. Monongalia County's PATCH organization has planned several projects, including a smoking and pregnancy project that will run from late August through September. Called "Freedom from Smoking for You and Your Baby," the project features a 10-day smoking cessation program with two follow-up meetings and a telephone support session. Participants will be awarded T-shirts for baby with the message, "I'm a born nonsmoker." The project planners have worked with local obstetricians so that a survey of pregnant women can be done.

Throughout the PATCH process, CDC personnel help train staffers and offer support. "CDC provides ongoing technical assistance to the state and communities. That's our role," says Ron Stoddard.

PATCH programs are now active in 12 states: Alabama, Connecticut, Florida, Kansas, Maine, Missouri, Nebraska, New York, Ohio, South Carolina, Utah, and West Virginia. "Our hope is that all the PATCH programs will be as successful as Monongalia County's and that PATCH will spread in other states as it has in West Virginia," says Ron Stoddard.

Communities Honored in Awards Program

On behalf of the Secretary of the U.S. Department of Health and Human Services, every two years CDC conducts the Community Health Promotion Awards. Established in 1982, the awards honor state and local community programs aimed at health promotion and disease prevention. Past award-winning projects have focused on topics such as smoking and health, alcohol and drug abuse, nutrition, physical fitness and exercise, hypertension, and accident prevention and injury control.

Awards for 1986 were announced in June, with 56 programs being granted the Secretary's Award for Excellence in Community Health Prevention. (For a listing of these programs, see MMWR, vol. 35, pp. 415-7.) Additionally, 141 projects received the Outstanding Community Health Promotion Award. All states and territories are eligible to apply for the 1988 program, which began in July. Each state or territory may select up to five proposals for submission. The deadline for submission of proposals is January 31, 1988; awards will be announced in June 1988.

Criteria for excellence include documented evidence of program effectiveness and the capacity for replication.

A publication describing the Secretary's Community Health Promotion Awards Program and the projects recognized in 1986 is available from the Division of Health Education at CDC, Attn: Richard A. Lasco, National Coordinator, Secretary's Community Health Promotion Program, (404) 329-3452 or FTS 236-3452.

Contributed by Richard A. Lasco, Center for Health Promotion and Education, CDC.

CHID - A New Source for Chronic Disease Information

Eleven clearinghouses and information databases have formed a consortium known as the Combined Health Information Database (CHID). CHID's purpose is to computerize the information holdings of U.S. Public Health Service (PHS) clearinghouses and to make these unique information resources available directly to the public.

The PHS has historically provided health information through two major sources. The first is the National Library of Medicine, the world's largest source of published biomedical information. Its resources are offered through the computerized system known as MEDLINE/MEDLARS and an interlibrary loan system involving the nation's medical libraries. The second major source of information is a network of subject-specific clearinghouses supported and operated by individual agencies within the PHS. There are about 20 of these clearinghouses and information databases, among which are the National Diabetes Information Clearinghouse, the Arthritis Information Clearinghouse, the Sudden Infant Death Syndrome Clearinghouse, and the Health Education Database. These databases include preventive health and disease-specific information that is needed by health practitioners but is not available in the traditional biomedical literature. This latter information, such as patient education curricula, audiovisuals, pamphlets, school health education curricula, policies, and guidelines, is included in CHID.

The idea behind CHID is innovative. The database consolidates health information collected by CDC, the National Institutes of Health (NIH), the Office of Disease Prevention and Health Promotion (ODPHP), and the Veterans Administration (VA), while still allowing each agency to retain responsibility for its individual areas of expertise. The current members of CHID are listed in the box below. CHID, as an umbrella-type system, is unlimited in the number of PHS clearinghouses that can join and, indeed, has grown from two online subfiles in 1984 to its current membership. It has also proved to be an economical way for agencies to share the costs involved in offering a computerized information dissemination system.

CHID is available to the public through the private computer vendor BRS Information Technologies. To access the system, the user needs a telecommunicating computer terminal or a personal computer equipped with a modem and a billing password from BRS. To obtain a password the user should write or call BRS Information Technologies, 1200 Route 7, Latham, New York 12110; telephone 1 (800) 345-4277. BRS charges $75.00 a year for the password and also bills the user for the time and use of its services. Training on how to search the BRS system is available throughout the United States, and BRS will provide the inquirer with specific dates and sites. Of particular interest is the BRS Colleague Service, the search service designed specifically for health professionals.

Most librarians, whether in medical libraries, universities, public libraries, health departments, hospitals, or schools, are now familiar with searching of databases that, like CHID, are available through commercial vendors. Because some libraries already have accounts with BRS that health professionals can use, persons wanting to search CHID may wish to check with their local libraries first.

Contributed by Priscilla B. Holman, Center for Health Promotion and Education, CDC.

CHID MEMBERS

National Diabetes Information Clearinghouse (NIH)
Arthritis Information Clearinghouse (NIH)
Digestive Diseases Clearinghouse (NIH)
High Blood Pressure Education Program (NIH)
National Cholesterol Education Program (NIH)
Veterans Administration Patient Education Clearinghouse (VA)
Health Education Database (CDC)
AIDS School Health Education Database (CDC)
National Health Information Clearinghouse (ODPHP)
Kidney Diseases Clearinghouse (NIH)
National Heart, Lung, & Blood Institute-Smoking Education Program (NIH)

Health Risk Appraisal - A New Tool for Chronic Disease Prevention

Since 1977, CDC, Health and Welfare Canada, and a national network of collaborating state health departments and research centers have worked to develop and improve health risk appraisal (HRA) as a public health and preventive medicine information tool. A new public-domain HRA computer program has recently been completed by the Carter Center of Emory University in collaboration with CDC. Twenty-four major health organizations and a nationwide network of state health departments have contributed to this effort. The project's goal was to develop a program that will facilitate an accurate and understandable personal risk assessment for individuals. The result is an inexpensive instrument that is fully documented, both scientifically and technically. The software, which can be readily modified for special target populations, is designed so that it can be easily updated as new scientific data become available. The project has been supported by grants from the Prudential Foundation, the W.K. Kellogg Foundation, the Morgan Guaranty Trust Company of New York, and Southern Bell.

Including elements of actuarial science, biostatistics, epidemiology, and health education, HRA has evolved considerably in recent years. It is now recognized as having major potential for chronic disease and injury prevention. Recent studies have shown that several of the currently used actuarial-method HRAs give valid estimates of the 10-year mortality rates for cardiovascular disease and for all causes of death. Although prediction based on HRA, by its very nature, is more readily validated for groups than for any particular individual, the technique is now accepted in the health community as a meaningful way of providing an individual with an objective estimate of preventable risks.

Based on reports from state health departments, the technique is highly popular with the general public, and—when combined with health professional interpretation and follow-up risk-reduction opportunities—it is believed to be an exceptionally effective health promotion technique. More recently, it is also being used by some agencies as an evaluation or tracking tool for assessing the effects of health promotion programs.

Release of the New Software

The completed HRA software program will be released on September 17, 1987, at a conference hosted by President and Mrs. Jimmy Carter at The Carter Presidential Center in Atlanta. "Healthier People" was selected as the title for this conference because the new HRA will inform individuals of the personal impact of risk factors identified in the 1979 Surgeon General's report, *Healthy People*. The software and its documentation will be made available through the 26 state health departments and three universities that currently participate in a national HRA technical assistance network supported by CDC's Center for Health Promotion and Education. For further information, contact: Dr. Edwin B. Hutchins, Health Risk Appraisal Program, The Carter Center of Emory University, 1989 N. Williamsburg Dr., Suite E, Decatur, GA. 30033, (404) 321-4104.

Contributed by Robert W. Amler, M.D., Office of Health Assessment, Agency for Toxic Substances and Disease Registry, and Edwin B. Hutchins, Ph.D., Health Risk Appraisal Program, The Carter Center of Emory University, Atlanta.

CDC Tests Chronic Disease Course

Directors of chronic disease activities from 18 states recently attended a CDC pilot course on management of chronic disease programs. On June 1-5, CDC hosted a field test of the course "Chronic Disease: A Public Health Approach." The states represented range from populous states with well-established chronic disease programs mandated by legislatures to sparsely populated states whose health departments employ one physician.

The idea for the course arose during the First National Conference on Chronic Disease Prevention and Control held in September 1986. Conference attendees from state health departments voiced the need for immediate training from CDC on planning and implementing chronic disease programs.

To design a training course, CDC formed a Chronic Disease Training Coordination Committee, comprising staff involved in chronic disease programs throughout CDC. The pilot also incorporated participants' suggestions from an April concept review meeting. The review group included three members of the target population plus a representative from the academic community and from the voluntary organizations.

CDC staff presentations early in the week focused on what chronic disease program managers need to know about epidemiology, surveillance, and evaluation. The diversity of experiences of course participants resulted in lively discussions later in the week. Topics included the many factors impinging on program priorities, barriers to programs that cut across the traditional boundaries of categorical diseases and constituencies, and difficulties inherent in applying infectious disease epidemiology to the emerging picture of chronic disease.

Participants' evaluations of the course have been positive. John Southard, Assistant Director for Chronic Disease Prevention in Maryland, wrote afterwards: "The course is a major milestone in chronic disease program development. It has already strengthened our communication links with other states and CDC operating units, and it has great potential for strengthened chronic disease activities in state and local health departments." Based on evaluations, CDC is committed to providing "Chronic Disease: A Public Health Approach" to participants from the remaining 32 states. Plans are under way to schedule the first course offering for this fall. CDC hopes that this course will help forge a partnership between states and Federal agencies as they face the increasing challenges of chronic disease prevention and control.

Participants in the pilot course included: Dileep G. Bal, M.D., of California; Charles Brokopp, M.D., of Idaho; Sherwood Zimmerman of Illinois; Randy Schwartz of Maine; John Southard, M.D., of Maryland; Donald E. Espelin, M.D., of Montana; Kathy Ward of Nebraska; Lawrence Matheis of Nevada; Richard DiPentima of New Hampshire; Lawrence Minert, M.D., of New Jersey; Sue Ripley of New Mexico; David Momrow of New York; Meredith Cosby of North Carolina; Frank Bright of Ohio; William Kcenich of Pennsylvania; Charlene Laramey of Texas; LaDene Larsen of Utah; and Fred Abrahamson of Washington.

For course information, contact Nancy Couey, Training and Laboratory Program Office, CDC, (404) 329-2137.

Contributed by Virginia Ross, Ph.D., Training and Laboratory Program Office, CDC.

Universities Awarded Prevention Centers Grants

On September 15, 1986, three universities received grants from CDC's Training and Laboratory Program Office (TLPO) to fund Prevention Centers that will conduct research and demonstration programs in health promotion and disease prevention. Grant recipients were the schools of public health at the University of Washington, the University of North Carolina, and the University of Texas at Houston.

This grant program was authorized by Public Law 98-551, which was enacted October 30, 1984. Schools of medicine, osteopathy, and public health were eligible to apply for grants. Twenty-three schools applied, and 16 were approved by a grant review committee; funds were sufficient to support only three Prevention Centers.

Prevention Centers are expected to help speed the progression of preventive medicine technologies from the basic research stage to practical, cost-effective applications. In particular, they are expected to develop economical means of achieving the Nation's 1990 Health Objectives.

The theme of the University of Washington Prevention Center is "Health Promotion and Disease Prevention in the Elderly." One of its major projects is a health promotion program for the elderly designed to reduce their need for health care and their days of restricted activity. The project's goals are to increase physical activity, reduce excessive use of prescription drugs and alcohol, and detect and correct visual and hearing deficits. As an additional benefit, the onset or the progression of some chronic diseases should be prevented or delayed for this group. This is a model program for the delivery of preventive health services directed at specific risk factors in a defined population group. The University of Washington Prevention Center is also studying methodologies for health risk assessment and is conducting a case-control study of hip fractures in the elderly.

The University of North Carolina Prevention Center is evaluating strategies for assessing risk factors for and modifying behaviors associated with cardiovascular disease. The objective is to develop a model for reducing the risk of cardiovascular disease. This Center will also focus on improving screening efforts to detect high blood pressure and breast and cervical cancer. Other projects include (1) an injury-prevention program designed to help local government officials implement ordinances and regulations proven to decrease injuries, (2) the development of self-help materials directed at improving diet and nutrition, and (3) a prepregnancy intervention program for controlling risk factors associated with low birth weight.

The University of Texas Prevention Center's theme is "From Healthy Children to Healthy Adults." This Center is directing its efforts toward intervention and health promotion among school-aged children. One study is focusing on the risks from cholesterol and lipids in childhood and adolescence and on possible interventions. A second effort focuses on the diets of school-aged children, with a view toward identifying and modifying cardiovascular risk factors. Other activities at this Center include the compilation of a database on cholesterol levels in childhood and the associated risk of cardiovascular disease, disease prevention among high-risk families identified through work site intervention programs, and health assessments for school-aged children.

The three Prevention Centers funded in fiscal year 1986 will receive continued funding in fiscal year 1987. Reauthorization of the Prevention Centers Program is pending before Congress. The program continues to grow with the designation in June 1987 of the University of Hawaii School of Public Health as the newest Prevention Center.

Contributed by Steven L. Solomon, M.D., Training and Laboratory Program Office, CDC.

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